

Tuskegee, AL 36083
(334)724-0550

Page: 1

9/21/2006

Patient: R. L. A.
P O Box 830122
Tuskegee, AL 36083Chart #: ARNRI000
Case #: 3305Instructions:

Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modify	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
10/13/2005	OFFICE VISIT INTERMEDIATE	99213		724.5	924.00			1	44.00
10/20/2005	OFFICE VISIT INTERMEDIATE	99213			924.00			1	44.00

**Provider Information**

Provider Name: Mollie Walker M.D.
License: [REDACTED]
Medicaid PIN: [REDACTED]
SSN or EIN: [REDACTED]

Total Charges:	\$ 88.00
Total Payments:	\$ 0.00
Total Adjustments:	\$ 0.00
Total Due This Visit:	\$ 88.00
Total Account Balance:	\$ 0.00

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: _____

Date: _____

Age: 12.1 yrs old., , Temp: 98 F., B.P: 110 / 80

Height: 64.5 in., Weight: 137 lbs.

History:

Chief Complaint: ER reck, injury to R thigh and L arm.

He sustained an injury to the right thigh 6 days ago. Type of injury: blow. The injury occurred at an extracurricular sport game. Other associated injuries: Left hip and Right arm. He complains of moderate pain. His pain is described as dull. The pain is localized to the right lateral thigh. His pain does not radiate anywhere. His pain is improving. His pain worsens with weight bearing. His pain improves with rest and over the counter pain medications. He complains of moderate swelling. He has had swelling since the injury. The swelling is localized to the lateral thigh. His swelling is improving over the past 3 days. He denies any stiffness. He denies any mass. Also c/o back pain Current medications; Motrin.

Review of Systems otherwise negative.

Physical Exam:

Vital signs are stable. He is well appearing, well developed, cooperative and. His neck is supple. His chest is clear to auscultation. Cardiovascular exam is regular rate and rhythm without murmur. His abdomen is soft, non-tender, non-distended, with positive bowel sounds and no HSM. Exam of both hips is normal. His neurologic exam is intact. He has a mild limp.

Additional Notes on Physical Exam:

Right Hip There is moderate swelling of the lateral thigh. There is no warmth. 6 by 6 cm area of contusion Right thigh.

Results:

L-S spine: pending.

Rx:

Motrin 600 tab 1 By mouth. Every 6 hours. Prn Pain, 40 (forty) Take with food. No Refill

Plan:

Discussed use of NSAIDS and crutches/cane. Instructions given, he is to call back or return to the office or ER if he worsens or develops other symptoms or if no better in 7 days. He is instructed to return to the office for a recheck in 2 weeks.

Diagnosis:

Primary Diagnosis: Contusion Right thigh

Age: 12.1 yrs old., , Temp: 96.8 F.

History:

Chief Complaint: Follow-up, R shoulder pain.

Type of Injury: blow. The injury occurred at an extracurricular sport game. He complains of moderate pain. His pain is improving over the past week. He complains of moderate swelling. His swelling is improving over the past week. He is currently taking Motrin 600 tab.

Review of Systems otherwise negative.

Physical Exam:

Vital signs are stable. He is well appearing, well developed and active. His chest is clear to auscultation. Cardiovascular exam is regular rate and rhythm without murmur. His abdomen is soft, non-tender, non-distended, with positive bowel sounds and no HSM. Exam of his right hip is normal. His neurologic exam is intact. He has a normal gait. Skin normal without rash. Exam of his right thigh is normal.

Plan:

Discussed use of NSAIDS. Instructions given, he is to call back or return to the office or ER if he worsens or develops other symptoms. may return to football practice.

Diagnosis:

Primary Diagnosis: contusion Right thigh

Electronically signed and coded by Dr. Walker -- 10/20/2005 -- 12:34:06

Patient Name: Dr. [REDACTED] A. [REDACTED]

Date: 10/13/2005

Doctor: Dr. Walker

Age: 12.1 yrs old., Temp: 98 F, B.P: 110 / 80

Height: 64.5 in., Weight: 137 lbs.

History:

Chief Complaint: ER visit, injury to R thigh and L arm.

He sustained an injury to the right thigh 6 days ago. Type of Injury: blow. The injury occurred at an extracurricular sport game. Other associated injuries: Left hip and Right arm. He complains of moderate pain. His pain is described as dull. The pain is localized to the right lateral thigh. His pain does not radiate anywhere. His pain is improving. His pain worsens with weight bearing. His pain improves with rest and over the counter pain medications. He complains of moderate swelling. He has had swelling since the injury. The swelling is localized to the lateral thigh. His swelling is improving over the past 3 days. He denies any stiffness. He denies any mass. Also c/o back pain Current medications: Motrin.

Review of Systems otherwise negative.

Physical Exam:

Vital signs are stable. He is well appearing, well developed, cooperative and. His neck is supple. His chest is clear to auscultation. Cardiovascular exam is regular rate and rhythm without murmur. His abdomen is soft, non-tender, non-distended, with positive bowel sounds and no HSM. Exam of both hips is normal. His neurologic exam is intact. He has a mild limp.

Additional Notes on Physical Exam:

Right Hip: There is moderate swelling of the lateral thigh. There is no warmth. 6 by 6 cm area of contusion Right thigh.

Results:

L-S spine: pending.

Rx:

Motrin 600 tab 1 By mouth. Every 6 hours. Prn Pain, 40 (forty) Take with food. No Refill

Plan:

Discussed use of NSAIDS and crutches/cane. Instructions given, he is to call back or return to the office or ER if he worsens or develops other symptoms or if no better in 7 days. He is instructed to return to the office for a recheck in 2 weeks.

Diagnosis:

11/1/07

COMMUNITY HOSPITAL
TALLASSEE, ALABAMA 36078

RADIOLOGY DEPARTMENT REPORT

NAME: ARNOLD RICHARD L	ACCT NUMBER: 620424
ROOM:	MR NUMBER:
STAY TYPE: E/R	DOB: 09/24/1993
AGE: 12	SEX: M
FILM #: 48464	PHONE: 334/725/1556
ADMIT: 10/10/05	ORDERING PHY: FARAH MAHI
DISCH DATE: 10/10/05	REFER PHY: WALKER MOL
TRANS. DATE: 10/11/05	F/C: XBI
TRANS. TIME: 8:15	
TRANS. INTL.: PM	

Unsigned Transcriptions represent a preliminary report and do not represent a medical or legal document*

<>XRAY ORDER<> COMPLETE: 10/10/05 1:17P CHI 233

Reason For Procedure: HIT WITH STICK ON FRIDAY

FEMUR RT COMPLETE: 10/10/05 1:17P CHI 241

SHOULDER LT 2 VIEWS COMPLETE: 10/10/05 1:17P CHI 242

PELVIS SINGLE VIEW COMPLETE: 10/10/05 1:17P CHI 243

DICT: 10/11/05

TYPED: 10/11/05 PM

RIGHT FEMUR, TWO VIEWS DATED 10/10/05:

FINDINGS:

There are no bony, articula, or soft tissue abnormalities.

IMPRESSION: (1). NORMAL RIGHT FEMUR SERIES.

PELVIS XRAY DATED 10/10/05:

FINDINGS:

The pelvic ring is intact. The joint spaces are well maintained.
No sacral fracture is demonstrated.

IMPRESSION: (1). NORMAL PELVIS.

LEFT SHOULDER, TWO VIEWS DATED 10/10/05:

FINDINGS:

There is no fracture or dislocation. The AC joint is intact. The soft tissues are unremarkable.

IMPRESSION: (1). NORMAL LEFT SHOULDER SERIES.

Dictated by: KENNETH JOE RICHARDSON, M.D.

This report has been Electronically Signed:
KENNETH R RICHARDSON
M.D.

COMMUNITY HOSPITAL
TALLASSEE, ALABAMA 36078

RADIOLOGY DEPARTMENT REPORT

NAME: ARNOLD RICHARD	ACCT NUMBER: 630941
ROOM:	MR NUMBER:
STAY TYPE: O/P	DOB: 09/24/1993
AGE: 12	SEX: M
FILM #: 48464	PHONE: 334/728/1556
ADMIT: 10/14/05	ORDERING PHY: WALKER MOL.
DISCH DATE: 10/14/05	REFER PHY: WALKER MOL.
TRANS. DATE: 10/17/05	F/C: XB
TRANS. TIME: 9:08	
TRANS. INTL: PM	

Unsigned Transcriptions represent a preliminary report and do not represent a medical or legal document*

=>XRAY ORDER<= COMPLETED: 10/14/05 11:35A WS 610

Reason For Procedure: LOW BACK PAIN

LUMBAR AP & LAT COMP & OBLIQUE COMPLETED: 10/14/05 11:35A WS 611

DICT: 10/17/05

TYPED: 10/17/05 PM

SCT

LUMBAR SPINE, FIVE VIEWS DATED 10/14/05:

FINDINGS:

The vertebral bodies are of normal alignment. The disc spaces are well maintained. There is no fracture. The pedicles are intact.

IMPRESSION: (1). NORMAL LUMBAR SPINE SERIES.

Dictated by: KENNETH JOE RICHARDSON, M.D.

This report has been Electronically Signed:

KENNETH R RICHARDSON

M.D.

SIGNED: _____

Copy for: WALKER MOILLE via fax

Copy for: 066 MEDICAL RECORDS

JVB309

STATE OF ALABAMA
COMPLAINT

PAGE: JU 2005 000111 OF

IN THE JUVENILE COURT OF MACON COUNTY, ALABAMA

IN THE MATTER OF: A. [REDACTED] JR.
ADDRESS: BOB SUSIE CIRCLESEX: [REDACTED]
PHONE: 000-000-0000
DOB: [REDACTED]

TUSKEGEE AL 36083

GRADE: [REDACTED] M

SCHOOL NAME: TUSKEGEE INSTITUTE MIDDLE SC

GRADE: 9TH GRADE: 10TH

SEX: [REDACTED]

PARENT: A. [REDACTED] JR.
ADDRESS: BOB SUSIE CIRCLECUSTODIAN:
ADDRESS:

TUSKEGEE AL 36083

HOME PHONE:

HOME PHONE: 000-000-0000

WORK PHONE:

MOTHER:
ADDRESS:VICTIM:
ADDRESS:HOME PHONE:
WORK PHONE:HOME PHONE:
WORK PHONE:

ALLEGED VIOLATION/INCIDENT: DISORDERLY CONDUCT

CATEGORY: DELINQUENT

DATE OF VIOLATION/INCIDENT: 10/07/2005

DATE OF ARREST: 00/00/0000

ARRESTING OFFICER:

DEPT:

I AGREE TO SIGN A FORMAL PETITION AND TESTIFY IN COURT IF NECESSARY
TO SUBSTANTIATE THE COMPLAINT.ATTAINANT: WALTER LACEY
ADDRESS: 642 00. ROAD 40
SHERIFF DEPT.: TUSKEGEE AL 36083SIGNATURE: *Walter Lacey #4623*
HOME PHONE: 000-000-0000
WORK PHONE: 334-727-2500

FACTS OF VIOLATION/INCIDENT:

ON OR ABOUT OCTOBER 7, 2005, RICHARD ARNOLD, JR DID INTENTIONALLY
ENGAGE IN DISORDERLY CONDUCT WITH INTENT TO CAUSE PUBLIC INCONVENIENCE,
ANNOYANCE OR ALARM, OR RECKLESSLY CREATED A RISK THEREOF BY
ENGAGING IN FIGHTING OR IN VIOLENT, TUMULTUOUS, OR THREATENING BEHAVIOR,
IN VIOLATION OF 13A-11-7(A)(1) OF THE CODE OF ALABAMA AGAINST THE PEACE,
AND DIGNITY OF THE STATE OF ALABAMA. SAID ACT OCCURRED IN MACON COUNTY,
ALABAMA.

DATE: 10/08/2005 TIME: 10:52 AM

Deneigh McFerrell
IN THE COURT

ACTION TAKEN:

(12/06/2005) MAX

PLAINTIFF'S
EXHIBIT